FUE CONT.

C.L. "BUTCH" OTTER – Governor RICHARD ARMSTRON – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

June 22, 2007

Phil Herink Sunhealth Behavioral Health System for Boise 8050 Northview Street Boise, Idaho 83704

RE: Sunhealth Behavioral Health System for Boise, provider #134009

Dear Mr. Herink:

Based on the Medicare/Licensure survey completed at Sunhealth Behavioral Health System for Boise on June 8, 2007 by our staff, we have determined that Sunhealth Behavioral Health System for Boise is out of compliance with the Medicare Hospital Conditions of Participation on Patients' Rights (42 CFR 482.13) and Medical Staff (42 CFR 482.22). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this condition to be unmet substantially limit the capacity of Sunhealth Behavioral Health System for Boise to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before <u>July 23, 2007</u>. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than <u>July 12, 2007</u>.

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.

Sunhealth Behavioral Health System for Boise June 22, 2007 Page 2 of 3

- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

Also pursuant to the provisions of <u>IDAPA 16.03.14.150.01.g</u>, Sunhealth Behavioral Health System for Boise is being issued a Provisional hospital license. The license is enclosed and is effective June 8, 2007, through October 8, 2007. The conditions of the provisional license are as follows:

- 1. Post the provisional license.
- 2. Correct all cited deficiencies and maintain compliance.

Please be aware, that failure to comply with the conditions of the provisional license, may result in further action being taken against the hospital's license.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit to the State Survey Agency a written request by **July 20**, **2007**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator Division of Medicaid -- DHW P.O. Box 83720 Boise, ID 83720-0036 phone: (208)364-1804

fax: (208)364-1811

Sunhealth Behavioral Health System for Boise July 22, 2007 Page 3 of 3

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (<u>IDAPA 16.05.03.301</u>).

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL, Supervisor

Non-Long Term Care

SC/mlw

Enclosure:

cc: Steve Millward

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief



#### SunBridge CEIVE BunHealth Behavioral Health System for Boise 8050 Northview St

JUL 13 2007

Boise, ID 83704 208.327.0504 Fax 208.327.0594

FACILITY STANDARDS

July 12, 2007

Ms. Sylvia Creswell Supervisor/Non-Long Term Care Idaho Department of Heath & Welfare Bureau of Facility Standards 3232 Elder Street Boise, ID 83720-0036

RECEIVED

JUL 1 2 2007

DIV. OF MEDICAID

Re: Credible Allegation of Compliance for Sunhealth Behavioral Health System for Boise, Provider #134009

Dear Ms. Creswell;

Pursuant to your letter dated June 22, 2007, I hereby submit the following letter of Credible Allegation of Compliance for the Medicare/Licensure survey completed on June 8, 2007. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in any subsequent Statement of Deficiencies.

The corrective actions identified below were completed as of the date of this letter of Credible Allegation of Compliance.

The following plan of action outlines immediate interventions employed by the Facility to correct the citations as alleged in the 2567 dated 06/08/2007:

#### A049

The Hospital has enhanced it's involuntary hold policy (formally Administrative Hold) that identifies documentation and evaluation procedures for staff to follow in the event a patient is a danger to self, others or gravely disabled and it is determined that an involuntary hold is necessary. In addition, a commutability assessment has been developed to evaluate the patient's psychological status and supports the claim of grave disability due to mental illness or imminent danger to self or others.

Evidence supporting the claim grave disability due to mental illness or imminent danger will be faxed to the dully authorized court within 24 hours.

Social Services, Licensed Nurses (RN, LPN) and the facility physicians have been in-serviced on the policy and documentation required for the process. The facility's Director of Social Services will audit patient charts of all involuntary holds to monitor the process to ensure that patient's rights are duly protected. All results will be reported to the facility's Quality Assurance, Medical Staff and Governing Board Committee and action plans developed for any issues noted.

#### A181

Please refer to Corrective Action provided under A049.

#### A185

The Hospital has developed a comfort care policy that will direct the staff on how to care for patients with a comfort care order. This policy is flexible enough that patients and/or families through the care plan process can provide input into what areas they would like treated or not. The facility's Licensed Nurses (RN, LPN) have been in-serviced on the policy and documentation required for the successful Implementation of this policy. The facility's DNS or designee will audit patient charts of all comfort care patients to monitor the process and care plan any concerns. All concerns will be addressed immediately. Medical staff is and continues to be accountable for the medical care provided to the patients via the peer review process. All results will be reported to the facility's Quality Assurance committee and action plans developed for any issues noted.

DNS or designee in conjunction with designated medical Staff will concurrently review clinical information to assure treatment is addressed appropriately and timely for identified infections. Variances will be reported to the Quality Assurance and Medical Executive Committees.

The facility's Preparation of Peer review policy has been updated to include a medical peer review. The facility will have 4 charts per quarter per physician including but not limited to medical review and unexpected clinical outcomes, death and family grievances. Results of the peer review will be presented to the Hospitals Medical Executive Committee and the Governing Board.

#### A204

All Licensed Nursing Staff have been in-serviced on the assessment and documentation of patients who are experiencing acute medical changes of conditions and notification to the attending physician when changes occur, including the facility's "Chest Pain-Angina" policy and the comfort care policy. Change of conditions will be reviewed on a daily basis through internal facility processes. The DNS or designee will audit charts of patients with acute medical changes of condition and look to see if proper assessments, documentation and physician notification occurred. Results will be presented to the facility's Quality Assurance committee and action steps taken for and issues noted.

#### A205

The Hospital has and continues to have nursing care plans for each patient. The Hospital has developed a comfort care policy that will direct the staff on how to care for these patients placed on comfort care. This policy will allow individualization for patients and families through the care plan process In addition nursing staff will care plan interventions for patients who have intrusive/wandering behaviors. All Licensed Staff (RN, LPN) have been in-serviced on the comfort care policy and the care planning process for interventions for patients with intrusive behaviors. The Director of Nursing or designee will audit patient charts for comfort care and behaviors to assure proper interventions/care plans are in place. Results will be presented to the facility's Quality Assurance committee and action steps taken for and issues noted.

Please accept this letter as our Credible Allegation of compliance. If you should have any questions regarding this letter of Credible Allegation of Compliance, please do not hesitate to contact me at 208-327-0504.

Sincerely.

Philip Herink

CEO

Chuck Bosen Brent Weil

cc:

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

August 15, 2007

Mr. Philip Herink, Administrator Sunhealth Behavioral Health System for Boise 8050 Northview Street Boise, Idaho 83704

Provider #134009

Dear Mr. Herink:

On **June 8, 2007**, a Complaint Investigation was conducted at Sunhealth Behavioral Health System. The complaint allegations, findings, and conclusions are as follows:

#### Complaint #ID00003056

Allegation #1: The hospital refused to discharge a patient when the patient's family requested that the patient be discharged to her home. The physician refused to discharge the patient to the husband without being granted power of attorney.

Findings: An unannounced visit was made to the hospital on 6/4/07 through 6/8/07. Clinical records, hospital policies, and quality improvement documents were reviewed and staff were interviewed.

The hospital's "Administrative Hold" policy, dated 11/4/04, stated the facility could "hold a patient against their will when the Medical Staff believes the patient may be at high risk for injury to self or others or so severely disabled from mental illness that the patient may be unable to care for self to provide food or shelter...In the event the patient announces a plan or intention to leave the hospital AMA (Against Medical Advice) the physician places the patient on Administrative Hold and initiates petition for a DE (Designated Examiner) to confine patient against their will." The policy did not adequately specify a procedure to evaluate patients for administrative hold nor did it specify a procedure to remove a patient from a hold once it had been implemented.

One patient record documented an 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. According to her discharge summary, dated 2/26/07, the patient was "very aggressive while she was at the hospital and the patient was very close to the end of her life and was placed on comfort measures." It further stated, the family of the patient had "expressed the desire for the patient to return home and die." The summary stated "they had problem-solved and set up hospice to visit in the home" on 2/25/07. An assessment to determine whether the patient was a danger to self or others or was gravely disabled due to psychiatric illness was not documented.

The patient's "Psychosocial Assessment," completed by the SW and dated 2/16/07, stated the patient's daughter had signed the patient into the hospital and the patient's husband, children and grandchildren all lived locally. Further, the assessment stated the daughter said that the patient wanted to go home and the patient's spouse wanted her to return home also. The assessment goal for hospitalization was to stabilize the patient so she could be discharged to a less restrictive setting. On 2/20/07, nursing notes and LSW progress notes stated the patient refused to eat or drink for the last 4 days and comfort measures were discussed with the family. An order for comfort measures was written by the physician on that day.

A nursing note in this patient's record, dated 2/23/07 at 3:30 PM, stated a meeting had taken place with the patient's husband, son and granddaughter regarding the patient being placed on an administrative hold due to the family wanting to take the patient home. A progress note from the patient's attending physician, dated 2/24/07, stated the family wanted to take the patient home on 2/23/07, "but nobody had power of attorney or guardianship so the patient was placed on a hold." An order by the attending physician, dated 2/23/07 but not timed, placed the patient on an administrative hold. An "Application for Commitment" was filled out but not signed, notarized, or filed with the courts. The commitment application stated the purpose for the hold was because the patient was grabbing at staff and other patients and was moaning out loud. It also stated the patient tried to bite an RN and was "biting hair and clothing."

On 6/6/07 at 8:10 AM, the patient's attending physician was interviewed. He stated, the family of the patient came to the hospital and wanted to take her home. He said he was concerned about the possibility of neglect due to the husband being elderly and frail. The physician stated he placed the patient on administrative hold to sort the situation out. He said the patient's granddaughter was involved with this decision and had agreed to the hold process. This statement was not supported by the granddaughter who was subsequently interviewed. The physician said he dropped the hold on 2/25/07 due to the granddaughter and hospice's involvement. He stated he felt comfortable to discharge the patient at that time. He said that putting the patient on a hold bought the hospital time to get the granddaughter and hospice involved.

Two other records were reviewed of patients who were placed on involuntary holds until family members provided evidence of power of attorney for health care. Neither record documented an evaluation showing the patients to be a danger to themselves or others or were gravely disabled by a psychiatric illness.

Idaho Statutes 66-326 provides that a patient in a hospital may only be held against their will if they are determined to be a danger to themselves or others or are gravely disabled by a psychiatric illness. Such a determination was not documented for the three cases noted above.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Deficiencies were cited at 42 CFR Part 482.13 Condition of Participation for Patient Rights.

**Allegation #2**: Patients often are left unattended and walk into other patients' rooms unsupervised.

Findings: Only one record reviewed documented wandering behavior. A male was admitted to the hospital on 2/1/07. The patient's medical record documented the following intrusive behaviors:

2/2/07 - "intrusive going into other patient's rooms"

2/3/07 - "going into other patient's rooms, inappropriate elimination"

2/5/07 - "intrusive... inappropriately voiding in trash cans"

2/7/07 - "intrusive to pt's rooms, getting in pt's beds empty or not"

2/9/07 - "in & out of pt rooms"

On 6/6/07 at 2:34 PM, a charge RN confirmed that the patient did wander into other patient's rooms. She stated that patients would sometimes wander "quickly in and out" of other patient's rooms. She stated they did not update or change a patient's "Plan of Care" if they had intrusive behaviors.

The acting Director of Nursing Services, on 6/7/07 at 3:50 PM, confirmed that the patient had wandered into other patient's rooms while he was in the hospital. Additionally, she confirmed that the patient's "Plan of Care" did not provide interventions to guide staff on how to prevent his intrusive behaviors.

The acting Director of Nursing Services, on 6/7/07 at 3:50 PM, confirmed that there were times when female patients did complain that male patients were wandering into their rooms. She stated that sometimes male patients did enter the female patients rooms at night but that no one had been harmed. She said that staff put up "Stop" or "Do Not Enter" signs on doors and that staff did 15 minute checks on all patients 24 hours a day. Additionally, she stated they would move a female patient closer to the nurses station if they were frightened.

Sunhealth Behavioral Health System For Boise August 15, 2007 Page 4 of # 8

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited. Deficiencies were cited at 42 CFR Part 482.23(b)(4) Nursing Care Plan.

Allegation #3: An identified patient was given intramuscular (IM) injections.

Findings: Eighteen clinical records were reviewed. One patient's record documented an 83 year female was admitted on 2/13/07 with diagnoses of vascular dementia with delusions. She was discharged on 2/25/07. According to her discharge summary, dated 2/26/07, the patient "would not take anything orally." On 2/20/07 (time not noted), the physician discontinued all oral medications and ordered IM medications. Further, the record documented that the patient was at times: very aggressive, delusional, combative, biting, hitting staff and would refuse oral medications resulting in receiving IM medications. A progress note from a Physicians Assistant dated 2/24/07, stated, the patient had a lower lobe pneumonia. The patient's "Nursing Progress Note" dated 2/24/07 at 5:00 PM, stated that the patient's husband and son opted for IM antibiotics to treat the pneumonia and this was ordered by the PA. The patient received IM medications as ordered on 2/16/07, 2/17/07, 2/18/07 (twice), 2/20/07, 2/22/07 and 2/24/07.

Medical records documented other patients had received IM medications as ordered when they were unable to take medications orally. Evidence of the over-medication of patients was not present in the records or observed during the survey. Patients did receive prescribed IM medications. However, the hospital did not act inappropriately by providing medications to patients through IM administration.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A patient's lips were bruised and cut and her face also had bruises.

Findings: Incident reports from 1/1/07 through 5/31/07 were reviewed. While a small number of bruises were noted, the facility had investigated these incidents and they were explainable. These were bruises on arms and legs. They appeared to be the result of falls or combative behavior. No bruising on patients' faces or other suspicious areas was documented. Photographs of a patient with bruises on her face and lips that were taken following hospitalization were reviewed by surveyors. The nurse, who discharged the patient in the photographs, and the patient's granddaughter, who drove the patient home, were interviewed. Both persons stated they did not notice any bruises on her face or lips at the time of discharge. The patient had been very combative with cares in the hospital. Bruises were documented on other parts of her body from these incidents. The patient was refusing food and fluids prior to her discharge, which can have unusual effects on the skin. No evidence of abuse was found.

Sunhealth Behavioral Health System For Boise August 15, 2007 Page 5 of # 8

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: A patient lost weight due to not being assisted with meals. The patient also became dehydrated.

Findings: Eighteen clinical records were reviewed. One patient's record documented an 83 year female that was admitted on 2/13/07 with diagnosis of vascular dementia with delusions. She was discharged on 2/25/07. According to her discharge summary, dated 2/26/07, the patient "would not take anything orally." The record contained a "Therapy Progress Note," that documented that the Speech Therapist had preformed an evaluation of the patient on 2/14/07. The evaluation stated, that the Speech Therapist had spoke extensively with spouse regarding the patient's eating skills. On 2/17/07 (un-timed), the Speech Therapist saw the patient and documented the following:

"Pt alert + holding on to staff throughout meal. O/A: Dysphagia: pt exhibits lengthy mastication (with) min oral residue (without) swallow. Pt exhibits occasional s/s of pain (with) mastication during meal holding her jaw + grimacing. Effective oral transfer noted (with) pureed diet consistency. St concern that if pt (changed) to pureed, pt will not recognize food + intakes will be further compromised...caregivers instructed to offer pureed items as snacks to maximize intakes." On 2/19/07 (un-timed), the Speech Therapist documented that "pt exhibiting significantly (decreased) alertness...poor intake." On 2/19/07 (un-timed), the Speech Therapist documented "pt exhibiting significantly (decreased) alertness...family had attempted to feed pt a bite of food which she did not masticate." The patient's "Food Intake Record" documented the patient had refused 24 of 39 meals and drank only 2,250 milliliters of fluids during meals over a 13 day period.

On 6/7/07 at 12:29 PM, a visit was made to the dining room to observe the lunch meal. Fifteen patients and two family members were in the dining room for the meal. Lunch consisted of turkey, mashed potatoes with gravy, a vegetable and pudding. Juice, milk, water and coffee were offered to patients along with their meal. Three staff members were present to serve the lunch and assist patients with eating. One staff member was observed to be cutting the turkey into bite size pieces while another staff member served the trays to patients. The third staff member was observed to encourage and assist patients to eat and drink when needed. When all patients had been served, two staff members were observed to encourage fluids and assist with eating. One staff member was observed feeding a patient who needed total assistance with his meal. Staff documented the percentage of the meal each patient ate and the amount of fluid consumed.

On 6/8/07 at 8:30 AM, an unannounced visit was made to the dining room to observe breakfast. Twelve residents were in the dining room for the meal and 5 staff members were there to assist. One table in the dining room had 2 patients who required total

Sunhealth Behavioral Health System For Boise August 15, 2007 Page 6 of # 8

Two staff members were sitting at the table to assist the patients with eating. The remaining 3 staff members encouraged the more independent patients to eat and drink.

A staff member, interviewed on 6/7/07 at 1:30 PM, stated that they circulated through the dining room and encouraged patients to eat and drink. She said they did assist patients who could not independently feed themselves. Further, she stated they frequently offered additional fluid and food to patients.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: An identified patient was left in bed without socks and was frequently cold.

Findings: During an unannounced visit made to the hospital from 6/4/07 through 6/8/07, patients were observed to be dressed appropriately. Patient's who were observed laying in bed had socks on. Additionally, staff were observed assisting patients with their dressing needs if the patient needed assistance.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: An identified patient was unable to hear and talk but was able to write. The hospital did not have a plan in place to communicate with the patient.

Findings: Two clinical records were reviewed of patients that had speech and/or hearing impairments. One patient's record documented an 83 year female admitted on 2/13/07 with diagnosis of vascular dementia with delusions. She was discharged on 2/25/07. According to her "Psychosocial Assessment," dated 2/13/07, the patient had had a stroke and suffered "expressive aphasia." On 2/14/07 (un-timed), the patient's physician ordered an consultation and treatment with a speech therapist. The record contained a "Therapy Progress Note" that documented that the Speech Therapist had preformed an evaluation on 2/14/07(un-timed) that stated, " development of communication book to facilitate (increased) effectiveness of communication." Further it documented follow up visits from the Speech Therapist on 2/17/07, 2/19/07 and 2/24/07. On 2/17/07 (un-timed), the Speech Therapist documented that "communication guidelines developed + staff training initiated." The medical record contained a "Communication Guidelines" for staff from the Speech therapist that stated:

"(Name) is very hard of hearing and has poor vision."

"(Name) will occasionally say a word that will make sense."

"Approach (Name) from the front only."

Sunhealth Behavioral Health System For Boise August 15, 2007 Page 7 of # 8

"(Name) will write single words. Sometimes they are related to what is going on. A lot of times the words are names of family members."

"Use gestures and gentle touch to let (Name) know what is going on."

"There is a communication book with simple words. You can try pointing to the word that relates to what you are doing."

"It is important to her to have a paper and pen to write with."

Another patient's admission history and physical, dated 1/04/07, documented the patient was very hard of hearing in both ears. A "Safety Device Evaluation" form, contained in the patient's record, documented that she could not hear and needed a "board" to communicate. The patient's "Plan of Care" also contained documentation that the patient was hard of hearing and required a "communication board" to communicate with.

On 6/7/07 at 3:50 PM, the acting Director of Nursing Services stated they frequently have patients at the hospital who are either hard of hearing or deaf. She stated they work with the family to assess the best was to communicate with the patient. She said they frequently use a "communication board".

Conclusion: Unsubstantiated. Lack of sufficient evidence.

The hospital conferred with families to assess the best ways to communicate with patients, provided speech therapy as needed, and documented in patient's records interventions needed to communicate the patients.

**Allegation #8**: An identified patient did not receive appropriate medical treatment.

Findings: An unannounced visit was made to the hospital on 6/4/07 through 6/8/07. Eighteen clinical records were reviewed and staff were interviewed. One patient's record documented an 83 year old female who was admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. She died on 2/27/07. On 2/13/07 a "Urinalysis Dip Screen" was performed on the patient's urine. The screen showed that the patient's urine contained, blood, urobilinogen, protein and nitrites. The Physicians Assistant's "Follow up Consultation", dated 2/15/07 at 3:46 PM, stated "patient is being seen today in follow up regarding her medical conditions... her UA was obtained two days ago showing positive for blood, urobilinogen, protein, and nitrate. UA culture is still pending." The "Assessment/Plan" section of the consultation stated, "will continue to monitor signs and symptoms. Will follow up with patient in the next three days or prn (as needed) or when lab tests are available." Laboratory results, dated 2/17/07 at 4:11 PM, documented the urine culture grew "Aerococcus Urinae." The results had the Physicians Assistant's initials on them. There was no further documentation in the

Sunhealth Behavioral Health System For Boise August 15, 2007 Page 8 of # 8

On 6/6/07 at 8:10 AM, the patient's attending physician stated, he was unaware of the patient's urine results. He said the Physicians Assistant usually follows the "treatment for patient's that have urinary tract infections." He further stated, that treatment was normally started for a positive urine dipstick and the prescribed antibiotics might be changed when the culture results were available.

On 6/6/07 at 3:30 PM, the Physicians Assistant stated he'd had a patient in the past, at another facility, that also grew out "Aerococcus Urinae". He stated, he had consulted with a physician at that time and was told that this bacteria was usually not treated when it was isolated in the urine. On 6/7/07 at 10:30 AM, the Physicians Assistant stated that he had thought about the patient further and had remembered why he did not treat the positive urinalysis. He said the decision not to tr1eat was made because it was unclear who had the power to make medical decisions for the patient at that time, so he had only ordered a culture. The Physicians Assistant did not consult with the patient's attending physician about the positive UA or culture results and antibiotics were not prescribed.

The hospital's peer review process was reviewed. It was determined no system was in place for the hospital to review the medical care patients received. In addition, the peer review the hospital had conducted was not in accordance with its policy.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Deficiencies were cited at 42 CFR Part 482.22 Condition of Participation for Medical Staff.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES Health Facility Surveyor Non-Long Term Care

SYLVIA CRESWELL

Supervisor

Non-Long Term Care

PRINTED: 06/22/2007 FORM APPROVED OMB NO. 0938-0391

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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
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	ensure that patients the right to make in The failure of the ho involuntary holds re against their will wit 482.13(b)(2) INFORTHE patient or his or allowed under State	the failure of the facility to or their representatives had formed health care decisions. It is a system for sulted in patients being held hout due process.	A 03	·		
	This STANDARD is Based on staff interrecords and facility phospital failed to ensepresentatives had health care decision of 5 sampled patien were placed on admindings include:  1. Idaho Statutes Tit DETENTION WITHIN DETENTION STATE AND TO THE PROPOSITION OUTSIONS O	s not met as evidenced by: view and review of medical policies, it was determined the sure that patients or their the right to make informed s. This affected the care of 4 ts (#s 5, 11, 13 and 18), who hinistrative holds. The le 66 Chapter 3, 66-326. OUT HEARING states, "(1) aken into custody or detained gency patient for observation, in, care or treatment of mental hill the court has ordered and custody under the in section 66-329, Idaho vever, that a person may be y a peace officer and placed erson may be detained at a person presented or was hedical or mental health care, ir a physician medical staff spital has reason to believe avely disabled due to mental		The Hospital has enhanced it's Inv hold policy (formally Administrati that identifies documentation and exprocedures for the staff to follow in event a patient is a danger to self, or gravely disabled and it is determine involuntary hold is necessary. In accommitability assessment has been developed to evaluate the patients psychological status and supports to figrave disability due to mental ill imminent danger to self or others. Application will be faxed to the duauthorized court within 24 hours. Services, Licensed Nurses (RN, LF the facility physicians have been in on the policy and documentation refor the process. The facilities Direct Social Service will audit patient chinvoluntary holds to monitor the prensure that patient's rights are duly protected. All results will be report facilities Quality Assurance, Medicand Governing board Committee and plans developed for any issues note.	ve Hold) evaluation the others or ed that an Idition a the claim mess or Illy locial PN) and eserviced equired stor of arts of all occess to ed to the eal Staff and action	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPLE CONSTRUCTION LDING	(X3) DATE S	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		STREET ADDRESS, CITY, STA 8050 NORTHVIEW STREI BOISE, ID 83704		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	JLD BE	(X5) COMPLETION DATE
A 049	illness or the persor imminent danger to evidenced by a thre harm; provided, und proposed patient be used for the detention convicted of penathis section, the terr state probation and their authority to supparolees. Whenever custody or detained court order, the evid grave disability due danger must be precourt within twenty-fithe individual was plotted to develop a procedure to evalual psychiatric status of hospital is limiting, and implement such 2. The hospital's "Activated 11/4/07, state hold a patient agains Staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual psychiatric status of hospital is limiting. The hold a patient agains Staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff believes the painjury to self or other from mental illness to care for self to proprocedure to evalual staff to proprocedure to evalual psychiatric status of hospital staff members and illness to care for self to proprocedure to evalual psychiatric status of hospital staff members and illness to care for self to proprocedure to evalual psychiatric status of hospital staff members and illness to care for self to proprocedure to evalual psychiatric status of hospital staff members and illness to care for self to proprocedure to evalual psychiatric status of hospital staff members and illness to care for self to proprocedure to evalual psychiatric status of hospital staff members and	n's continued liberty poses an that person or others, as at of substantial physical der no circumstances shall the detained in a nonmedical unit on of individuals charged with al offenses. For purposes of m'peace officer' shall include parole officers exercising pervise probationers and er a person is taken into under this section without dence supporting the claim of to mental illness or imminent sented to a duly authorized our (24) hours from the time faced in custody or detained." It which allows a "physician er" to detain a person against it the responsibility of the and implement a coherent the and document the the person whose rights the The hospital failed to develop a procedure.  Imministrative Hold" policy, d in its entirety "Purpose: To st their will when the Medical attent may be at high risk for its or so severely disabled hat the patient may be unable	A (	049		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION  NG	(X3) DATE S COMPLI	ETED
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	ROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE	,	8	REET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
A 049	event the patient ar leave the hospital A or appears by their elopement, physicia Administrative Hold (Designated Examiagainst their will. 3 threatens physical hincluding leaving agstaff is to call police patient's elopement policy did not state evaluate the patient how the results of the documented. Furth how evidence suppressented within 24 hours from detained, as required 3. The records of 4 11, 13 and 18), who Administrative holds documentation of an need to place the patient documented to a cour hold the patient againclude:  *Patient #5 was an admitted on 2/13/07 dementia with delus 2/25/07. A telephor documented), place	d charge nurse. 2. In the inounces a plan or intention to IMA (against medical advice) behaviors to be planning an places patient on and initiates petition for a DEner) to confine the patient. If patient persists and narm to staff up to and initiation of petition." The now the hospital should is psychological status and nat evaluation would be er, the policy did not state orting the claim of grave in the time the individual was ad by the above law.  of 5 sampled patients (#s 5, were placed on a did not contain in evaluation demonstrating a latient on an involuntary hold. In Patients #5, 13, and 18 did intation that evidence was a supporting the decision to inst his/her will. Examples	A (	049			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPL LDING	E CONSTRUCTION	(X3) DATE S COMPL	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		805	ET ADDRESS, CITY, STATE, ZIP CODE 10 NORTHVIEW STREET ISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 049	progress note from 2/24/07 (the following family wanted to take nobody had power of She was going to be is very frail and bipped a good situation for were issues prior to put her on a hold at out. There is apparable to identify as a to wait and see how feel she could go he the situation it looked. The form "Application out but not signed, of the courts. The Apstated the purpose for grabbing @ staff and moaning out loud. The form and clothing." documentation of an imminent danger by state law. Also, the patient was going to stated in the hospitation the hold was written Again, there was no note explaining why On 6/6/07 at 8:10 Alphysician was intervof Patient # 5 came take her home. He the possibility of negotians.	time the hold was ordered. A the patient's physician, dated ing day), documented "The se her home yesterday but of attorney or guardianship. It with her aging husband who olar son. I didn't feel that was her or safe anyway. There coming into the hospital. So I this time to get that sorted ently a daughter we may be potential guardian. Will have that shakes out but I didn't ome safely anyway based on ad like she was going into." On for Commitment", was filled dated, notarized, or filed with plication for Commitment for the hold was because "Pt d residents refused to let go trying to bite RN. Biting staff The record did not contain in evaluation demonstrating a latient on an involuntary hold or ent was gravely disabled or to self or others as required the record did not state the leave AMA or elope, as al's policy. An order to drop on 2/25/07 at 12:45 PM. accompanying physician the hold was dropped.  W, the patient's attending fiewed. He stated, the family to the hospital and wanted to said he was concerned about plect due to the husband being alth and the son having a	A	049			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SI COMPLE	ETED
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	ROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		81	REET ADDRESS, CITY, STATE, ZIP CODE 050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 049	psychiatric illness a decisions. He said administrative hold said the patient's gray with this decision as process. (The grar she was interviewed said he dropped the granddaughter and said he felt comfort at that time. He said know what specific going to provide. He hold bought the host granddaughter and patient's care.  On 6/6/06 at 1:30 Pethe patient was place there was no plan to said, however, that patient to return hor to ensure Patient #2 appropriate cause.  Patient #11 was a 7 admitted on 3/23/07 depression. An investment applicant settle application of the patient's record con Commitment' dated 3/26/07. The application and per proposed patient's a Handwritten on the	and the family not making good he placed the patient on to "sort all of this out." He randdaughter was involved and had agreed to the hold addaughter disputed this when do no 6/7/07 at 1:10 PM.) He hold on 2/25/07 due to the hospice's involvement. He able to discharge the patient id, however, that he did not services the hospice was e said putting the patient on a spital time to get the hospice involved in the  M, the SW stated the reason and the discharge plan was for the me all along. The facility failed to was detained for an  6 year old female who was with a diagnosis of major coluntary hold was ordered by any physician on 3/24/07. The tained an "Application For It, signed and notarized on cation form stated the the proposed patient (#11) is sely to injure self or others or is sed on the following sonal observations of the	A	049			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE S	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	times. Pt stating share of her animals state why the physicherself or gravely discontain documentated demonstrating a neinvoluntary hold. In "Letter of Authority the County Prosecu The patient was dis 3/29/07. There was record or in Departrecords that the patine Designated Examindocumentation that released by the county Prosecu *Patient #18 was a the hospital on 5/18, psychotic disorder a She was currently a physician's order, or for the patient to be A nursing note, at 6 arrived (with) son arto bring meds and conce (name) started from the same place stated "Pt asked to the asked if he would tall she didn't need to be son that she was dispatient was described she had won 20 milli was not described as the state of the same place she had won 20 milli was not described as the same pla	the wants to go home to take "The application did not be be be as a danger to sabled. The record did not be	. A (	049			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE S COMPL	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 049	disabled. No physi present in the record Assessment", dated admitted for delusion described as neat a was oriented to per assessment said should be assessment said the patient of the RN on duty who was interviewed on stated the patient who stated the patient where so the social worker for the social worker for 6/6/07 at 4:20 Pl not have an assess on an administrative said the legal paper the hold was not prehe could not tell who on a hold. Patient # interviewed on 6/8/0 had seen the patient document the encounter that Patient #18 was regarding her treatmeded to be held as *Patient #13 was a *Patient #14	cian's note for 5/18/07 was rd. The "Nursing Admission d 5/18/07, form stated she was and thinking. She was and clean in appearance. She son, place, and time. The ne was not hallucinating and a threat to others. No court in the record. An order, red to drop the administrative tient had a durable power of care.  The patient #18 was admitted, 6/6/07 at 2:30 PM. She had not assessed the rake decisions regarding her patient #18 was interviewed with the stated the patient did ment of the need to be placed at hold in her record. He also work placing the patient on esent in the record. He said at Patient #18 had been placed the sent in the record. He said at 9:15 AM. He stated he to no 5/18/07 but had failed to cunter. There was no evidence is unable to make decisions nent at the hospital and against her will.	A	049			
	the hospital on 3/13 dementia. A nursing	/07 with a diagnosis of g note at 5:45 PM on 3/13/07 lert & awake. Ambulating self.				The second section of the sect	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		FIPLE CONSTRUCTION NG	(X3) DATE S COMPL	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		8	REET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 049	Dtrs accompanied. dinner" At 10:10 PM documented "Pt. ve Pt refused meds, redressed sitting on companied." Sawake all night wait for the patient to be was documented or "Initial Psychiatric Estated she was confused she was confuncted to the patient to be was documented or "Initial Psychiatric Estated she was confuncted she was confuncted she was confuncted to the state of the social was present in documenting the horecord. The social was administrative hold requesting to leave. working on guardian meet with their attor PMAdministrative and faxed to the Ada office." The Social was 1:30 PM, stated the daughter obtained godocumented in the redisposition of the capatient's physician reasonable to the hold we record.	Pt taken down to DR for M that evening, the nurse ry angry about being in facility. Efuses to go to bed & is fully ouch by nurses station waiting rup. Pt. withdrawn, some the apparently remained ing to leave. A verbal order placed on administrative hold in 3/14/07 at 10:25 AM. The valuation", also dated 3/14/07, fused but did not document laced on a hold or the reason ician note documenting the the record. A nursing note lid was not present in the vorker's note, dated 3/14/07 Patient was placed on an due to her repeatedly Patient's daughtersare iship. They were going to ney this date at 3:00 paper work was notarized a County prosecuting attorney Worker, interviewed on 6/6/07 ne hold was dropped after the uardianship. This was not ecord. No record of the legal se was documented. The eviewed the record on 6/8/07 and an evaluation of the re not documented in the		)49			
A 181	staff that operates up	TAFF  ave an organized medical nder bylaws approved by the is responsible for the quality	A 1	81			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE	S	TREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
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A 185	of care provided to  This CONDITION Based on staff interrecords and facility hospital failed to made quality of care provided to the failure of the facts aff were accounted medical care provided for the hospital to made quality of medical care provided for the hospital to made quality of medical care provided for the medical staff of the medic	patients by the hospital.  s not met as evidenced by: view and review of medical policies, it was determined the aintain responsibility for the ded to 4 of 7 sampled patients Refer to A49 as it relates to sility to ensure that medical ble for the quality of the ed to the patients. The failure aintain responsibility for the are resulted in the delay of ts and a lack of direction to  AFF ACCOUNTABILITY  ust be well organized and governing body for the quality provided to the patients.  ust be organized in a manner verning body.  nas an executive committee, a bers of the committee must ine or osteopathy.  r organization and conduct of list be assigned only to an medicine or osteopathy or,	A 18	Refer to A049 for Plan of Correct:	afort care how to is flexible es through input into or not.  N, LPN) and eccessful es facilities thats of or the as will be taff is and	
		State law of the State in which ed, a doctor of dental surgery		care provided to the patients via the review process. All results will be to the facilities Quality Assurance committee and action plans develoany issues noted.	reported	
1		1		7/10/	07	1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURV	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		8	REET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 185	This STANDARD is Based on staff inter records and facility hospital failed to en accountable for the provided to the patic 4 of 7 sampled patic whose conditions whospital failed to en an identified urinary Finally, the hospital treatment provided The findings include 1. Four of seven sar 15) had orders for "of the hospital had not to how to care for the include:  * The Acting DNS, in AM, stated the hospital had not to how to care for the include:  * The Acting DNS, in AM, stated the hospital with diagree defined comfort meadirection to staff as it patients.  * Patient #2 was an the hospital with diagreesion as well a accident, atrioventric gastro-esophageal releading ulcer. He whe died at the hospital physician progress regradually declined a physician ordered "of physician progress resonance for this the rationale for this	s not met as evidenced by: view and review of medical policies, it was determined the sure the medical staff was quality of the medical care ents. This affected the care of ents (#s 1, 2, 5, and 15), ere terminal. In addition, the sure that 1 of 3 patients, with tract infection, was treated. failed to ensure the medical to patients was evaluated.  Exampled patients (#s 1, 2, 5, and comfort measures". However, provided direction to staff as ese patients. Examples  Interviewed on 6/5/07 at 10:50 ital had no policy which asures and had not provided to how to care for these  89 year old male admitted to gnoses of dementia and is post cerebrovascular		185			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IULTIPLE CONSTRUCTION LDING		(X3) DATE S COMPL	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		STREET ADDRESS, CITY, 8050 NORTHVIEW ST BOISE, ID 83704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRI	'S PLAN OF CORREC' ECTIVE ACTION SHO ENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 185	Treatment team no document the decis comfort measures. Change Form" writt stated "Family required measures." On 5/1 documented the paint able to feed him PM stated "early in (with) cares & sustatear. Cleansed & dishift, gurgling resps O2 on at 2-3 (liters) patient died at 12:15 documentation was was notified of the condition. The Actinat 11 AM, stated the notified of the sudde condition. She specialled the physician were ordered for the *Patient #1 was a 9 admitted to the hosp diagnoses which incomplysician ordered "opatient's record did interventions to guid comfort care. The patient #15 was a admitted to the hosp which included Alzhe psychotic features a	fes for 5/8/07 did not sion to place the patient on An un-timed "Condition en by a nurse on 5/8/07, ested pt be placed on comfort 4/07 at 1:30 PM, the nurse tient was up in the wheel chair nself. The nursing note at 10 shift, res combative & resistive ined rt elbow 1-1.5 cm skin ressing & steri on. End of (HOB up) O2 sat R/A 70% & per comfort care." The 5 AM on 5/15/07. No present that the physician change in the patient's ap DNS, interviewed on 6/8/07 a physician should have been en change in the patient's culated that the nurse had not because comfort measures a patient.	A 1	85			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1	IULTIPL ILDING	E CONSTRUCTION	(X3) DATE S COMPL	ETED
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	PROVIDER OR SUPPLIER ALTH BEHAVIORAL H	EALTH SYSTEM FOR BOISE		805	ET ADDRESS, CITY, STATE, ZIP CODE 0 NORTHVIEW STREET ISE, ID 83704	4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 185	medical condition g 2/6/07, the attending measures". The particle documented interversion of comfort hospital on 2/17/07.  * Patient #5 was and to the hospital on 2/17/07 was discharged from Social Worker progradocumented that, discussed with the fordered by the physis.	radually declined and on g physician ordered "comfort tient's record did not contain entions to guide staff in the care. The patient died at the 83 year old female admitted 13/07 with a diagnosis of with delusions. The patient in the hospital on 2/25/07, ress notes, dated 2/21/07, uring a treatment team comfort measures were amily and subsequently ician. The patient's record did nted interventions to guide	A 1	85			
	at 8:10 AM. He state not have an official repolicy defining what "red flag" for staff to medical illnesses we aggressively. He resumble and stated the nurse when the patient's confurther direction. The stated he did not alwellow placing a patient on a thought the nurse didiscretion to not admixed he with low oxygen saturated comfort measure how the nurse would interviewed on 6/8/0" #2's nurse probably of the staff of	r was interviewed on 6/7/07 ed "comfort measures" did meaning and there was not it meant. He said it was a alert them that the patient's ere not going to be treated viewed Patient #2's record e should have called him condition changed to seek e Medical Director also vays write a note when comfort measures but d. He said the nurse had the ninister oxygen to a patient eration levels if the patient eration levels if the patient eration this. The acting DNS, 7 at 10:15 AM, stated Patient did not call the physician condition changed because the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION IG	(X3) DATE S COMPL	
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	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		8	REET ADDRESS, CITY, STATE, ZIP CODE 050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 185	patient had orders if said there was no pressures and thes nurse.  2. Three sampled pevidence of a UTI. that 1 of these paties rationale for not treat the physician was a managed period of the patient is urine of the patient is urine of the patient is being seen that the patient is being seen the medical condition two days ago showing urobilinogen, protein still pending. The "the consultation statistics and symptoms in the next three day available." Laborated 4:11 PM, document "Aerococcus Urinae initials on them. The documentation in the positive urine results."  On 6/6/07 at 8:10 All patients and the patient is pending. The "the consultation in the positive urine results."	or "comfort measures". She olicy which defined comfort a were left up to the individual catients had documented. The hospital failed to ensure ents (#5) was treated or that a sting her was documented. The hospital failed to ensure ents (#5) was treated or that a sting her was documented. The hospital failed to ensure ents (#5) was treated or that a sting her was documented. The patient's UTI.  I year old female who was with a diagnosis of vascular ions. She was discharged the died on 2/27/07. On the patient of the patient, was performed enter the patient of the patient's record about the patient's record about the patient's attending the patient at the patient at the patient'	A	185	DNS or designee in conjunction wi designated medical Staff will concureview clinical information to assurt reatment is addressed appropriately timely for identified infections. Var will be reported to the Quality Assurand Medical Executive Committees 7/12/0	erently re y and riances urance	
	physician stated he urine results. He sa	was unaware of the patient's id the PA usually follows the it's that have UTI's." He					***************************************

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		134009	B. WII	√G			C 08/2007
	ROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		805	ET ADDRESS, CITY, STATE, ZIP CODE 50 NORTHVIEW STREET DISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 185	for a positive urine antibiotics might be results were available. On 6/6/07 at 3:30 P patient in the past, a grew out "Aerococo consulted with a phytold that this bacteri when it was isolated 10:30 AM, the PA s about the patient furwhy he did not treat decision not to treat unclear who had the decisions for the part only ordered a cultur with the patient's attraction prescribed. Also clarify who had the patient's attraction of the patient of the p	dipstick and the prescribed changed when the culture ole.  M, the PA stated he'd had a set another facility, that also us Urinae". He stated he had ysician at that time and was a was usually not treated in the urine. On 6/7/07 at tated that he had thought of the positive UA. He said the was made because it was a power to make medical tient at that time, so he had re. The PA did not consult ending physician about the re results and antibiotics were on the PA did not seek to power to make medical of determine if the UTI should	Α	185			
	provided to patients to care for elderly patents behavioral illnesses. hospital were frequented multiple medical Patient #2 was a typold and had diagnost accident, atrioventric gastro-esophageal ribleeding ulcer in addementia and depresses accidents.	The hospital's mission was atients with psychiatric and Patients treated at the ently in their 80s or 90s and I diagnoses. For example, ical patient. He was 89 years ses of post cerebrovascular					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED					
		134009	B. WIN	√G		1	C 8/2007
	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		80	EET ADDRESS, CITY, STATE, ZIP CODE 050 NORTHVIEW STREET OISE, ID 83704	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 185	treated medical corpsychiatrists who treated hospital had a to evaluate the care hospital did not have medical care of pat. The policy "PREPA REVIEW", dated 10 records per physiciar reviewed. The Directing interviewed 6/6/07 aphysician per quartecases sent for reviewed physician were sent the reviews. Only physician were sent the reviews. Only physician were sent the reviews. She stated random. She said a selected based on precific criteria.  The physician who are review for the facility a psychiatrist. The REVIEW-PSYCHIA used for all peer review form that addressed medical illnesses with problems, including acknowledged by the During the exit interthe CEO stated their specific to evaluatin medical illnesses.  A letter, dated 4/25/	nditions in addition to eated psychiatric conditions. peer review process in place of psychiatric illnesses. The re a process to evaluate the	A 1	85	The facilities Preparation of Peer repolicy has been updated to include peer review. The facility will have Per quarter per physician including limited to medical review and unex clinical outcomes, death and family grievances. Results of the peer revibe presented to the Hospitals Medic Executive Committee and the Gove Board.  7/12/07	a medical 4 charts but not epected www.ill cal erning	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CONSTRUCTION  _DING		(X3) DATE SURVEY COMPLETED	
		134009	B. WIN		1	C <b>)8/2007</b>	
	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 204	member had questi patient. The letter's investigated the car an interview, on 6/8 stated a physician pcase in order to deticare was appropriat with the patient's attregarding the approprovided to Patient no formal method to complaints or poor (482.23(b)(3) RN SU CARE  A registered nurse rethe nursing care for	oned the medical care of the stated the CEO had e the patient received. During /07 at 1:30 PM, the CEO beer had not reviewed the ermine whether or not the se. He said he had only talked tending physician priateness of the treatment #5. He said the hospital had be evaluate care in response to outcomes.  IPERVISION OF NURSING must supervise and evaluate each patient.	A 20	04	an in		
	Based on review of policies and staff int hospital failed to ensupervised and eval of 6 patients (#s 2 a reviewed, that had distaff did not properly patient's physicians. The findings include. The hospital's "Chest 11/4/2004, documer chest pain would be duty. This assessmutial signs, noting the color and degree of complete description assessing other pos	clinical records, hospital erview, it was determined the sure a registered nurse uated the nursing care for 2 nd 14), whose records were lied in the hospital. Nursing assess, document or call of acute medical changes.  Et Pain-Angina" policy, dated ated that any patient reporting fully assessed by the RN on ent was to include: a set of e patient's skin temperature, moisture, obtaining a n of the patient's pain and sible causes of the pain. The to the physician of the		All Licensed Nursing Staff have be serviced on the assessment and documentation of patients who are experiencing acute medical change conditions and notification to the at physician when changes occur, inclifacilities "Chest Pain-Angina" polithe comfort care policy. Change of conditions will be reviewed on a dathrough internal facility processes. or designee will audit charts of patiacute medical changes of condition to see if proper assessments, document physician notification occurred will be presented to the facilities Quality Assurance committee and action staffor any issues noted.	s of tending luding the cy and sily basis The DNS ents with and look nentation . Results		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE S COMPL	
		134009	B. Wil	1G		06/	C 08/2007
	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		80	EET ADDRESS, CITY, STATE, ZIP CODE 150 NORTHVIEW STREET OISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 204	the patient's conditi- persisted or vital signurse would then cat transferred to the ne policy had not been  * Patient #14 was a admitted on 2/23/07 Disease with aggres the hospital on 3/1/0 note, dated 3/1/07 r was confused but as stated the patient widue to "not eating of Patient #14's nursin documented the foll 12:35 PM. "Pt confussist. Pt (refused) encouraged pt to sta night)."  1:15 PM. "(Short of back on - heart rate (with) head elevated 9:25 PM. "Pt sitting i Says his chest hurts breathing. Visible as 10:40 PM. "No pulse The patient's medica documented evidency had obtain vital signs	s for follow up instructions. If on began to deteriorate, if pain in the partial part of the partial part of the part of the partial part of the part	A 2	204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TULTIF	PLE CONSTRUCTION	(X3) DATE COMPL	.ETED
		134009	B. WII	VG		06/	C 08/2007
	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		80	EET ADDRESS, CITY, STATE, ZIP CODE 150 NORTHVIEW STREET OISE, ID 83704	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
A 204	obtained a descript possible causes of documented evider the patient's physici change in his condition of the nurse who work complained of chest at the hospital and of the acting DNS was 2:15 PM. She confident of the change accurate assessme staff did not properly patient's physician to acute medical change.	ion of the pain or other pain. Lastly, there was no oce that the nurse had called an to report the suddention.  Ked at the time the patient had to pain and died was no longer was not available for interview. In interviewed on 6/8/07 at remed there was no dicate the physician had been ge of condition or that an ont was done. The nursing y assess, document or call to notify him of the patient's ge.	A 2	204			
	the hospital with dia depression as well a accident, atrioventric gastro-esophageal r bleeding ulcer. He of 5/15/07. According his medical condition 5/8/07, the attending measures". On 5/14 documented the pat and able to feed him PM stated "early in s (with) cares & sustaitear. Cleansed & dr shift, gurgling resps O2 on at 2-3 (liters) patient died at 12:15 documentation was nursing assessment	eflux disease with a history of died at the hospital on to physician progress notes, or gradually declined and on a physician ordered "comfort 14/07 at 1:30 PM, the nurse lient was up in the wheel chair uself. The nursing note at 10 chift, res combative & resistive ned rt elbow 1-1.5 cm skin essing & steri on. End of (HOB up) O2 sat R/A 70% & per comfort care."					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONSTRUCTION LDING	(X3) DATE COMP	SURVEY LETED
		134009	İ	IG		C <b>08/2007</b>
	PROVIDER OR SUPPLIER ALTH BEHAVIORAL H	EALTH SYSTEM FOR BOISE		STREET ADDRESS, CITY, STATE, ZIP 8050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 204	patient's condition. on 6/8/07 at 11 AM, have been notified of patient's condition.  The hospital failed t supervised and eva hospital. Nursing st document or call pa medical changes. 482.23(b)(4) NURSI	The Acting DNS, interviewed stated the physician should of the sudden change in the o ensure a registered nurse luated the nursing care in the aff did not properly assess, tient's physicians of acute	A 2			
	This STANDARD is Based on medical reinterview, it was dete ensure staff develop 4 patients (#'s 1, 2, 8 ordered comfort carefailed to develop a n patients (#15) whose intrusive behaviors, potential for unmet pinclude:  1. Nursing staff faile plans that guided state to terminal patients.  * Patient #1 was a 98 admitted to the hosp diagnoses which included at the hospital ophysician progress n	not met as evidenced by: ecord review and staff ermined the hospital failed to ed nursing care plans for 4 of 5 and 15) whose physician's e measures. Further, staff ursing care plan for 1 of 2 e records were reviewed for These failures resulted in the atient needs. The findings  d to develop nursing care eff in providing comfort care		The Hospital has and commursing Care plans for each Hospital has developed a policy that will direct the care for these patients placare. This policy will allow individualization for patients through the care plan production protection of the patients who have introughted the care plan for patients who have introughted the care plan for patients who have introughted the care plannical interventions. All Licensed Shave been in serviced on the policy and the care plannical interventions for patients behaviors. The Director of designee will audit patient comfort care and behavior proper interventions/care place. Results will be presented in the presented that the presented in the plant in the presented in the pres	ch patient. The comfort care staff on how to ced on comfort ow ents and families cess In addition in interventions rusive/wandering staff (RN, LPN) the comfort care ing process for with intrusive of Nursing or t charts for rs to assure plans are in sented to the ce committee	

	T OF DEFICIENCIES OF CORRECTION	RECTION I DENTIFICATION NUMBER: A. BUILDING COMPLI					
		134009	B. Wii	VG_		06/0	C 08/2007
	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		1	REET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 205	physician ordered "patient's POC did n direct staff on the p * Patient #2 was an the hospital with dia depression as well accident, atrioventri gastro-esophageal bleeding ulcer. He 5/15/07. According his medical conditio 5/8/07, the attending measures". The pato reflect this order of take. This was confo/8/07 at 11 AM. * Patient #5 was an to the hospital on 2/vascular dementia v was discharged from Social Worker progradocumented that du meeting, on 2/20/07 discussed with the fisubsequently ordere patient's POC did no interventions to guid comfort measures.  * Patient #15 was a admitted to the hosp which included Alzher was a supported to the hosp which included Alzher was a supported by the subsequently ordered patient's POC did not interventions to guid comfort measures.	comfort measures". The ot provide interventions or rovision of comfort measures.  89 year old male admitted to gnoses of dementia and as post cerebrovascular cular block, and reflux disease with a history of died at the hospital on to physician progress notes, in gradually declined and on g physician ordered "comfort tient's POC was not changed or what actions nurses should firmed by the acting DNS on  83 year old female admitted 13/07 with a diagnosis of with delusions. The patient in the hospital on 2/25/07, ress notes, dated 2/21/07, ring a treatment team, comfort measures were	A 2	205			
	to physician progres gradually declined as	ospital on 2/17/07. According s notes, his medical condition and on 2/6/07, the attending omfort measures". The					

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	AULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		134009	B. Wii	VG		06/0	C 08/2007
•	PROVIDER OR SUPPLIER ALTH BEHAVIORAL H	EALTH SYSTEM FOR BOISE		80	EET ADDRESS, CITY, STATE, ZIP CODE 050 NORTHVIEW STREET OISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 205	patient's POC did n direct staff on the p On 6/6/07 at 2:34 P comfort care consis wanted. She stated policies and proced providing comfort meach nurse to decid On 6/7/07 at 3:50 P hospital did not have guide staff in provid patients. Additional the patients, whose contain POCs that is wishes or provide in the provision of com  2. Nursing staff fails staff in implementing Patient #15 from wa or other inappropria a 63 year old male thospital on 2/1/07 w Alzheimer's dement combative behaviors:  The patient's medica following behaviors:  2/2/07 at 6 PM - "intipatient's rooms"  2/3/07 at 3 PM- "goin inappropriate elimina 2/5/07 at 9:45 PM - "voiding in trash cansi	ot provide interventions or rovision of comfort measures.  M, a charge RN stated that sted of whatever a family if the hospital did not have ures to guide staff on heasures, that it was up to be what cares were needed.  M, the acting DNS stated the expolicies and procedures to ing comfort care to terminal ly, she confirmed that none of records were reviewed, incorporate patient/family terventions to guide staff in infort measures.  Bed to develop a POC to guide guinterventions to prevent indering into patients' rooms to behaviors. Patient #15 was hat was admitted to the with diagnoses which included its with psychotic features and its.  Bed record documented the rusive going into other magnito other patient's rooms, action"  'intrusive inappropriately intrusive inappropriately intrusive to pt's rooms, getting	A 2	205			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2007 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP ILDING	LE CONSTRUCTION	(X3) DATE : COMPL	SURVEY .ETED
		134009	B. WII			C 06/08/2007	
	PROVIDER OR SUPPLIER	EALTH SYSTEM FOR BOISE		808	ET ADDRESS, CITY, STATE, ZIP CODE 50 NORTHVIEW STREET DISE, ID 83704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 205	2/9/07 at 9 AM - "in The patient's POC of staff how to prevent DNS confirmed on 6	& out of pt rooms"  did not document or direct these behaviors. The acting 6/7/07 at 3:50 PM, that the s the patient's intrusive or	A 2	205			

PRINTED: 06/22/2007 FORM APPROVED Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 134009 06/08/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8050 NORTHVIEW STREET SUNHEALTH BEHAVIORAL HEALTH SYSTEM BOISE, ID 83704 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) B 000 16.03.14 Initial Comments B 000 The following deficiencies were cited during the complaint investigation survey of your hospital for compliance with state licensure. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS Patrick Hendrickson, RN, HFS Acronyms used in this report include: Administrative hold = Involuntary hold CEO = Chief Executive Officer CNA = Certified Nursing Assistant DE = Designated Examiner DNS = Director of Nursing Services RECEIVED HR = Heart Rate IM = Intramuscular PA = Physician Assistant JUL 13 2007 POC = Plan of Care POA = Power of Attorney PT = patient FACILITY STANDARDS R/A = Room AirRN = Registered Nurse SW = Social Worker UA = Urine Analysis UTI = Urinary Tract Infection BB144 16.03.14.250.01 Medical Staff Qualifications and **BB144** Privileges 250, MEDICAL STAFF. The hospital shall have an active medical staff

Bureau of Facility Standards

LABORATORY DIRE PLIER REPRESENTATIVE'S SIGNATURE

organized under bylaws approved by the

governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88)

STATE FORM

3U6K11

Refer to Plan of Correction A185

7/12/07

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134009  E OF PROVIDER OR SUPPLIER  STREET ADDR		(X2) MULT A. BUILDIN B. WING _		(X3) DATE S COMPL		
NAME OF P			STREET AD	STREET ADDRESS, CITY, STATE, ZIP CODE			
	SUNHEALTH BEHAVIORAL HEALTH SYSTEM			RTHVIEW S 83704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
BB144	01. Medical Staff Q medical staff membrand professionally, are granted. (10-14 a. Privileges shall be individual training, of (10-14-88)  b. The medical staff approval, shall dever procedure for determedical staff appoint privileges. (10-14-8 c. The governing be privileges within the capabilities for provand equipment in sprivileges within the capabilities for provand equipment in sprivileges and facility hospital failed to enaccountable for the provided to the patical 4 of 7 sampled patical whose conditions whospital failed to enance identified urinary Finally, the hospital treatment provided The findings included 1. Four of seven saft 15) had orders for "However, the hospital Housever, the hospital failed to enace identified urinary finally, the hospital treatment provided The findings included 1. Four of seven saft 15) had orders for "However, the hospital failed to enace identified urinary finally, the hospital treatment provided The findings included 1. Four of seven saft 15) had orders for "However, the hospital treatment provided The findings included 1. Four of seven saft 15) had orders for "However, the hospital treatment provided The findings included 1.	ualifications and Privolers shall be qualified for the privileges whealth and privileges whealth are granted only on the competence, and experiment, and for determining qualifications and the shall approve mealth and for determinity of the hospital iding qualified suppoperior and review of molicies, it was determined to the medical stanguality of the medical stanguality	d legally ich they e basis of perience.  dy a written for rmining edical staff l's price staff p-14-88)  nedical mined the ff was al care he care of 15), ition, the ents, with treated. medical pated.  , 2, 5, and direction	BB144			
			-				1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION G	(X3) DATE S	LETED	
		134009	Carrier and	<u> </u>	27 A 27 21 2 A 22 E	<u> </u>	)8/2007	
NAME OF F	PROVIDER OR SUPPLIER		I		STATE, ZIP CODE			
SUNHEA	ALTH BEHAVIORAL H	EALTH SYSTEM	8050 NOF BOISE, ID	RTHVIEW ST 83704	REET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
BB144	Continued From pa	ige 2		BB144				
	* The Acting DNS, AM, stated the hos defined comfort me	interviewed on 6/5/0' pital had no policy wl easures and had not to how to care for th	nich provided					
	the hospital with dia depression as well accident, atrioventr gastro-esophageal bleeding ulcer. He he died at the hosp physician progress gradually declined a physician ordered "physician progress the rationale for this progress notes also Treatment team no document the decis comfort measures. Change Form" writt stated "Family require measures." On 5/1 documented the paint able to feed hir PM stated "early in resistive (with) care cm skin tear. Clear End of shift, gurglin 70% & O2 on at 2-3 The patient died at documentation was was notified of the condition. The Actiat 11 AM, stated the notified of the suddentified of	as post cerebrovascicular block, and reflux disease with a was admitted on 4/3 ital on 5/15/07. According to the second of the s	and ular  history of 0/07 and ording to ondition tending The ot state ent order. ent on tion b/07, n comfort nurse heel chair ote at 10  which is a 10  care."  No rsician 's on 6/8/07 ave been ient's					
	End of shift, gurglin 70% & O2 on at 2-3. The patient died at documentation was was notified of the condition. The Actinat 11 AM, stated the notified of the suddecondition. She specific properties of the suddecondition.	g resps (HOB up) O28 (liters) per comfort of 12:15 AM on 5/15/07 present that the phychange in the patienting DNS, interviewed on change in the patient on change in the patient	2 sat R/A care." 7. No rsician 's on 6/8/07 ave been ient's e had not					

PRINTED: 06/22/2007 FORM APPROVED

Bureau of Facility Standards STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

134009

IDENTIFICATION NUMBER:

A. BUILDING B. WING \_\_\_\_\_

06/08/2007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## SUNHEALTH REHAVIORAL HEALTH SYSTEM

8050 NORTHVIEW STREET

SUNHEALTH BEHAVIORAL HEALTH SYSTEM		BOISE, ID	83704	REEI	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB144	Continued From page 3		BB144		
	were ordered for the patient.				
	* Patient #1 was a 95 year old male that was admitted to the hospital on 4/13/07 with diagnoses which included dementia. According to physician progress notes, his medical condition gradually declined and, on 4/21/07, the attending physician ordered "comfort measures". The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The patient died at the hospital on 4/30/07.				
	* Patient #15 was a 63 year old male who was admitted to the hospital on 2/1/07 with diagnoses which included Alzheimer's dementia with psychotic features and combative behaviors. According to physician progress notes, his medical condition gradually declined and on 2/6/07, the attending physician ordered "comfort measures". The patient's record did not contain documented interventions to guide staff in the provision of comfort care. The patient died at the hospital on 2/17/07.  * Patient #5 was an 83 year old female admitted to the hospital on 2/13/07 with a diagnosis of vascular dementia with delusions. The patient was discharged from the hospital on 2/25/07. Social Worker progress notes, dated 2/21/07, documented that, during a treatment team meeting on 2/20/07, comfort measures were discussed with the family and subsequently ordered by the physician. The patient's record did not contain documented interventions to guide staff in the provision of comfort care.				
	The Medical Director was interviewed on at 8:10 AM. He stated "comfort measure not have an official meaning and there w cility Standards	s" did			

PRINTED: 06/22/2007 FORM APPROVED Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B WING 134009 06/08/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **8050 NORTHVIEW STREET** SUNHEALTH BEHAVIORAL HEALTH SYSTEM BOISE, ID 83704 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) BB144 BB144 Continued From page 4 policy defining what it meant. He said it was a "red flag" for staff to alert them that the patient's medical illnesses were not going to be treated aggressively. He reviewed Patient #2's record and stated the nurse should have called him when the patient's condition changed to seek further direction. The Medical Director also stated he did not always write a note when placing a patient on comfort measures but thought the nurse did. He said the nurse had the discretion to not administer oxygen to a patient with low oxygen saturation levels if the patient had comfort measures ordered. It was not clear how the nurse would know this. The acting DNS, interviewed on 6/8/07 at 10:15 AM, stated Patient #2's nurse probably did not call the physician when the patient's condition changed because the patient had orders for "comfort measures". She said there was no policy which defined comfort measures and these were left up to the individual nurse. 2. Three sampled patients had documented evidence of a UTI. The hospital failed to ensure that 1 of these patients (#5) was treated or that a rationale for not treating her was documented. The physician was not aware of the patient's UTI. Patient #5 was a 83 year old female who was

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admitted on 2/13/07 with a diagnosis of vascular dementia with delusions. She was discharged home on 2/25/07. She died on 2/27/07. On 2/13/07 a "Urinalysis Dip Screen," was performed on the patient's urine. The screen showed that the patient's urine contained, blood, urobilingen,

Consultation", dated 2/15/07 at 3:46 PM, stated,

protein and nitrites. The PA's "Follow up

"Patient is being seen today in follow up regarding her medical conditions... her UA was obtained two days ago showing positive for blood.

	NT OF DEFICIENCIES I OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY  COMPLETED			
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SUNHEA	LTH BEHAVIORAL H	EALTH SYSTEM	8050 NOF BOISE, ID	ORTHVIEW STREET ID 83704					
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BB144	urobilinogen, protei still pending." The the consultation sta signs and symptom in the next three da available." Laborat 4:11 PM, document "Aerococcus Urinaci initials on them. The documentation in the positive urine result.  On 6/6/07 at 8:10 A physician stated he urine results. He sa "treatment for patie further stated, that is started for a positive prescribed antibiotic culture results were On 6/6/07 at 3:30 P patient in the past, a grew out "Aerococcus consulted with a phe told that this bacter when it was isolated 10:30 AM, the PA sabout the patient further why he did not treat decision not to teat unclear who had the decisions for the particular still be a cultured as cultured as cultured as cultured as a cultured	n, and nitrate. UA of "Assessment/Plan" ated, "will continue to as. Will follow up with a particular or presults, dated 2/sted the urine culture at the was no further are patient's record at sor possible treatment. Why the patient's attential the PA usually for a treatment was normed at another facility, the customer at another facility, the patient at that time at a was usually not treatment was normed at another facility, the patient at that time at the positive UA. He was made because a power to make meatient at that time, so are. The PA did not	section of o monitor th patient the patient she tests are 117/07 at a grew the PA's bout the ment.  Inding a patient's bllows the "He had an at also ted he had and was eated 17/07 at ought mbered a said the ait was edical to he had consult	BB144					
	with the patient's at positive UA or cultu not prescribed. Als clarify who had the decisions in order to be treated.	re results and antibi o, the PA did not se power to make med	iotics were ek to lical						

PRINTED: 06/22/2007 FORM APPROVED Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 134009 06/08/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **8050 NORTHVIEW STREET** SUNHEALTH BEHAVIORAL HEALTH SYSTEM BOISE, ID 83704 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **BB144** BB144 Continued From page 6 3. The hospital had not developed and implemented a system to review the medical care provided to patients. The hospital's mission was to care for elderly patients with psychiatric and behavioral illnesses. Patients treated at the hospital were frequently in their 80s or 90s and had multiple medical diagnoses. For example, Patient #2 was a typical patient. He was 89 years old and had diagnoses of post cerebrovascular accident, atrioventricular block, and gastro-esophageal reflux disease with a history of bleeding ulcer in addition to diagnoses of dementia and depression. The hospital had specific physicians and mid-level providers who treated medical conditions in addition to psychiatrists who treated psychiatric conditions. The hospital had a peer review process in place to evaluate the care of psychiatric illnesses. The hospital did not have a process to evaluate the medical care of patients. The policy "PREPARATION FOR PEER REVIEW", dated 10/21/04, stated four medical records per physician per quarter would be reviewed. The Director of Health Information. interviewed 6/6/07 at 11 AM, stated 3 records per physician per quarter were reviewed. A list of cases sent for review documented 3 records per physician were sent. The hospital was behind on the reviews. Only nine records per physician had been peer reviewed since 1/1/06. The Director confirmed this. She said she chose the cases for

specific criteria.

review. She stated these cases were selected at random. She said cases for review were not selected based on poor outcomes or other

The physician who conducted all of the peer review for the facility, since January 1, 2006, was

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(10-14-88)

shall include but is not limited to: (10-14-88)

a. Nursing care treatments required by the

b. Medical treatment ordered for the patient; and

patient; and (10-14-88)

7/12/07

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	,	134009		B. WING _		06/0	8/2007	
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BB175	Continued From pa	ge 8		BB175				
	c. A plan devised to include both short-term and long-term goals; and (10-14-88)							
		y teaching plan both scharge; and (10-14						
	e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88)							
	This Rule is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure staff developed nursing care plans for 4 of 4 patients (#'s 1, 2, 5 and 15) whose physician's ordered comfort care measures. Further, staff failed to develop a nursing care plan for 1 of 2 patients (#15) whose records were reviewed for intrusive behaviors. These failures resulted in the potential for unmet patient needs. The findings include:							
		ed to develop nursin taff in providing comf						
	* Patient #1 was a 95 year old male that was admitted to the hospital on 4/13/07 with diagnoses which included dementia. The patient died at the hospital on 4/30/07. According to physician progress notes, his medical condition gradually declined and on 4/21/07, the attending physician ordered "comfort measures". The patient's POC did not provide interventions or direct staff on the provision of comfort measures.							
	the hospital with dia	89 year old male ad agnoses of dementia as post cerebrovasci icular block, and	and					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	COMF	
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BB175	gastro-esophageal bleeding ulcer. He 5/15/07. According his medical condition 5/8/07, the attending measures. The part of the reflect this order take. This was con 6/8/07 at 11 AM.  * Patient #5 was and to the hospital on 2/2 vascular demential was discharged from Social Worker programmented that dure meeting, on 2/20/07 discussed with the first subsequently order patient's POC did not interventions to guid comfort measures.	reflux disease with a died at the hospital of to physician progres on gradually declined attent's POC was not or what actions nursifirmed by the acting a 13/07 with a diagnowith delusions. Them the hospital on 2/2 ress notes, dated 2/2 uring a treatment teat, comfort measures family. These were ed by the physician of contain document de staff in the provisual on 2/17/07 with one staff in the provisual on 2/17/07. Tradually declined and physician ordered attent's POC did not part of the hospital did not uses to guide staff on the provisual of the hospital did not ures to guide staff on the provisual of the hospital did not ures to guide staff on the provisual of the hospital did not ures to guide staff on the provisual of the hospital did not ures to guide staff on the provisual of the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the hospital did not ures to guide staff on the provisual contains the provisual contains the provisual contains the hospital did not ure the provisual contains the provisual contains the provisual contains the provisual contains the provisual contains the provisual contains the provisual contains the provisual contains the provisual contains the provisual contains the provisual c	on ss notes, d and on "comfort t changed ses should DNS on admitted sis of patient 25/07. 21/07, am swere The ted ion of nat was diagnoses ith viors. The His d on "comfort provide sion of ted that mily have n	BB175			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN		(X3) DATE SURVEY COMPLETED	
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BB175	Continued From page 10			BB175			
	On 6/7/07 at 3:50 PM, the acting DNS stated the hospital did not have policies and procedures to guide staff in providing comfort care to terminal patients. Additionally, she confirmed that none of the patients, whose records were reviewed, contain POCs that incorporate patient/family wishes or provide interventions to guide staff in the provision of comfort measures.  2. Nursing staff failed to develop a POC to guide staff in implementing interventions to prevent Patient #15 from wandering into patients' rooms or other inappropriate behaviors. Patient #15 was a 63 year old male that was admitted to the						
	hospital on 2/1/07 v Alzheimer's dement combative behavior	with diagnoses which tia with psychotic fea rs.	included itures and				
	following behaviors	cal record documente :	ed tille	:			
	2/2/07 at 6 PM - "intrusive going into other patient's rooms" 2/3/07 at 3 PM- "going into other patient's rooms, inappropriate elimination" 2/5/07 at 9:45 PM - "intrusive inappropriately voiding in trash cans" 2/7/07 untimed - "intrusive to pt's rooms, getting in pt's beds empty or not" 2/9/07 at 9 AM - "in & out of pt rooms"						
	The patient's POC did not document or direct staff how to prevent these behaviors. The acting DNS confirmed on 6/7/07 at 3:50 PM, that the POC did not address the patient's intrusive or inappropriate behaviors.						
BB182	16.03.14.310.10 Sta	aff Assignments		BB182			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING B. WING			COMPLETED		
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BB182	10. Staff Assignment make assignments a. In the absence of Services, an RN shifthe director's duties b. There shall be a times. (10-14-88) c. There shall be two nurse coverage in conformation of the accordance with Susmall hospitals may nurse on call to the are no patients in the d. No person will be (aides and orderlies duty in the facility duty) hours, except in e. There shall be supersonnel in all cate patient care. (10-14-15. Personnel who has infectious wound or and who provide can be required to imple control techniques as	nts. Registered nurse for nursing care. (10 fthe Director of Nursell be designated to a (10-14-88) registered nurse on the enty-four (24) hour registered nurse on the enty-four (24) hour registered nurse and available recritical care areas in basection 420.02.d. En have an available recritical care unit. (10 final care unit) assigned nursing the preceding the included) who has a furing the preceding the an emergency. (10 fficient numbers of regories to ensure qual-88)  In a communicable of the entype	sing assume duty at all registered exception: egistered en there 12-31-91) uties been on welve 0-14-88) nursing ality of disease, conditions ents shall ction tration; or us stage area d and absent; the	BB182	Refer to Plan of Correction	n A204	7/12/07
	nursing care to nurs						

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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BB182	Continued From page 12			BB182				
	in Idaho and shall c and regulations, and direction of the app i. Private duty nurse critical care areas u	es shall be currently comply with all hospit do be under the generopriate DNS. (10-14 es shall not be assignates properly orient policies and procedures.)	al rules ral I-88) ned to ted and					
	This Rule is not met as evidenced by: Based on review of clinical records, hospital policies and staff interview, it was determined the hospital failed to ensure a registered nurse supervised and evaluated the nursing care for 2 of 6 patients (#s 2 and 14), whose records were reviewed, that had died in the hospital. Nursing staff did not properly assess, document or call patient's physicians of acute medical changes. The findings include:							
	The hospital's "Chest Pain-Angina" policy, dated 11/4/2004, documented that any patient reporting chest pain would be fully assessed by the RN on duty. This assessment was to include: a set of vital signs, noting the patient's skin temperature, color and degree of moisture, obtaining a complete description of the patient's pain and assessing other possible causes of the pain. The RN would then notify the physician of the assessment findings for follow up instructions. If the patient's condition began to deteriorate, if pain persisted or vital signs become unstable, the nurse would then call 911 and have patient transferred to the nearest emergency room. This policy had not been followed. Examples include:  * Patient #14 was a 88 year old male who was admitted on 2/23/07 with diagnosis of Alzheimer's							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE S	
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PRÉFIX (EACH DEFICIENCY				PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
the hospital on 3/1/0 note, dated 3/1/07 r was confused but a stated the patient w due to "not eating o Patient #14's nursin documented the foli 12:35 PM. "Pt confussist. Pt (refused) encouraged pt to state (at night)."  1:15 PM. "(Short of back on - heart rate (with) head elevated (with) head elevated 9:25 PM. "Pt sitting Says his chest hurts breathing. Visible a 10:40 PM. "No pulse The patient's medical documented evidential obtain vital sign temperature, moistur documented evidential sign temperature evidential sign tempe	ssive behaviors. He 07. A physician's proport timed, stated the twake and alert." It fires "going down hill per drinking."  In g notes, dated 3/1/0 lowing:  I used, (up) in w/c (with meds &food & fluids ay (up) today d/t poor for breath.) SPO2 88 - very irreg. Pt now ind 90 (degrees)."  In bed stiff and (not) is. HR irregular. Mountaious."  I we, (no) respirations."  I we from the nurse the sor noted the patier are or color. There we ce that the nurse has on of the pain or other pain. Lastly, there we ce that the nurse has an to report the suddition.  I we dat the time the patier was not available for was not available for the suddition.	ogress "patient urther ohysically" 7, th one) s. Staff or sleep O2 put on bed moving. th no of the skin of the ski	BB182			

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Bureau of Facility Standards

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BB182	Continued From para 2:15 PM. She confidocumentation to innotified of the changaccurate assessmentaff did not properly patient's physician that acute medical changes are patient's physician that acute medical changes are patient, atrioventric gastro-esophageal bleeding ulcer. He 5/15/07. According his medical conditions 5/8/07, the attending measures. On 5/1 documented the parand able to feed him PM stated "early in resistive (with) care cm skin tear. Clear End of shift, gurgling 70% & O2 on at 2-3. The patient died at documentation was nursing assessment physician was notific patient's condition. On 6/8/07 at 11 AM, have been notified of patient's condition.  The hospital failed that supervised and evaluation was document or call paramedical changes.	irmed there was no adicate the physiciar ge of condition or the that was done. The ry assess, document to notify him of the page.  89 year old male ad agnoses of dementia as post cerebrovaso icular block, and reflux disease with a died at the hospital to physician progreson gradually declined g physician ordered 4/07 at 1:30 PM, the tient was up in the waself. The nursing rashift, res combatives & sustained rt elboased & dressing & sig resps (HOB up) OB (liters) per comfort 12:15 AM on 5/15/0 present that a compt was performed or led of the change in The Acting DNS, in stated the physician of the sudden change of the sudden change in the sudden change of the sudden change in the sudden change of the sudden change of the sudden change in the sudden change of the sudden change in the sudden change in the sudden change of the sudden change in the sudden change	at an nursing tor call patient's dmitted to a and cular a history of on ss notes, d and on "comfort e nurse wheel chair note at 10 & ow 1-1.5 teri on. 2 sat R/A care." 7. No olete that the the terviewed in should be in the assess,	BB182			